



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

TUBERCULOSIS SURVEILLANCE FOR PATIENTS

Effective Date: July 21, 2011

Policy #: IC-16

Page 1 of 4

- I. PURPOSE:** To provide guidelines for tuberculosis surveillance.
- II. POLICY:** To ensure admission screening and yearly surveillance of patients at Montana State Hospital (MSH).
- III. DEFINITIONS:**
- A. PPD – Tuberculin Purified Protein Derivative
 - B. BCG or Bacille Calmette – Guerin – A vaccine for Tuberculin disease
 - C. TST – Tuberculin Skin Test
 - D. IGRA - Interferon-Gamma Release Assays (IGRAs) are whole-blood tests that can aid in diagnosing Mycobacterium tuberculosis infection, including both latent tuberculosis infection (LTBI) and tuberculosis (TB) disease. Two of the four IGRAs that have been approved by the U.S. Food and Drug Administration (FDA) are commercially available in the U.S. They are:
 - 1. QuantiFERON®-TB Gold In-Tube test (QFT-GIT)
 - 2. T-SPOT®.TB test (T-Spot)
- IV. RESPONSIBILITIES:**
- A. RN or LPN is responsible for administering TST on admission unless contraindicated.
 - B. RN or LPN is responsible for follow-up reading of TST after administration and documentation of results on the immunization record.
 - C. Medical Clinic Physician or designee is responsible for reviewing PPD skin test status at time of annual physical and ordering appropriate surveillance.
- V. V. PROCEDURE:**
- A. ADMISSIONS

All new admissions to Montana State Hospital should receive 2-step tuberculin skin testing unless there is written documentation of a negative TST within the past 12 months.

The tuberculosis skin test is contraindicated for patients with known active tuberculosis, a documented positive TST, or a documented severe hypersensitivity to purified protein derivative such as vesiculation, ulceration or necrosis at the test site

A chest x-ray will be ordered on any patient with an ongoing contraindication to PPD testing as deemed appropriate by a medical clinic physician.

B. TUBERCULOSIS SURVEILLANCE

In addition *current residents*, except those with known active tuberculosis, documented positive TST or IGRA, or a documented severe hypersensitivity to purified protein derivative such as vesiculation, ulceration or necrosis at the test site should participate in an annual testing program.

Patients with a previously positive TST must have documentation of a negative chest x-ray and will receive TB screening through Medical Clinic.

Patients who have known exposure to active tuberculosis will have a tuberculosis skin test six weeks after the exposure.

If using the TST, the first step should be applied at admission according to the following protocol. If the first TST is negative, the second test should be placed one to three weeks after placement of the first test. A documented negative TST result within the past 12 months may be considered the first step. If the IGRA is used, one blood sample should be drawn at admission. No additional samples are required. The IGRA can only be authorized by Medical Clinic Physicians and approval by the Medical Director.

Protocol for Tuberculin Skin Testing (TST)

Note: A patient with written documentation of a previous positive TST does not need a repeat tuberculin skin test.

Intradermally inject 0.1 cc of intermediate strength purified protein derivative containing 5 tuberculin units in the volar or hairless area of the forearm about 4 inches below the elbow, creating a wheal 6-10mm in size. Repeat the tuberculin skin test on the opposite arm or three (3) inches from original test site if the wheal created is not of adequate size.

The TST is read between 48-72 hours. Measure the area of INDURATION, a hard, dense, raised formation (erythema or redness - does not indicate a positive reaction). The number of millimeters of INDURATION is recorded.

If there is <5 mm of induration or no reaction at all, the test is considered negative. Always record the test results in millimeters (mm) and not as “negative”.

Classification of the Tuberculin Reaction

An **induration of 5 or more millimeters** is considered positive in;

- HIV-infected persons
- A recent contact of a person with TB disease
- Persons with fibrotic changes on chest radiograph consistent with prior TB
- Patients with organ transplants
- Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF- α antagonists)

An **induration of 10 or more millimeters** is considered positive in;

- Recent immigrants (< 5 years) from high-prevalence countries
- Injection drug users
- Residents and employees of high-risk congregate settings
- Mycobacteriology laboratory personnel
- Persons with clinical conditions that place them at high risk
- Children < 4 years of age

An **induration of 15 or more millimeters** is considered positive in;

- Any person, including persons with no known risk factors for TB
However, targeted skin testing programs should only be conducted among high-risk groups.

C. TESTING FOR TB IN BCG-VACCINATED PERSONS

BCG, or Bacillie Calmette-Guérin, is a vaccine for TB disease. Many persons born outside of the United States have been BCG-vaccinated. BCG vaccination may cause a positive reaction to the TB skin test, which may complicate decisions about prescribing treatment. Despite this potential for BCG to interfere with test results, the TB skin test is not contraindicated for persons who have been vaccinated with BCG. The presence or size of a TB skin test reaction in these persons does not predict whether BCG will provide any protection against TB disease. Furthermore, the size of a TB skin test reaction in a BCG-vaccinated person is not a factor in determining whether the reaction is caused by latent TB infection (LTBI) or the prior BCG vaccination.

TB blood tests (interferon-gamma release assays or IGRA), unlike the TB skin tests, are not affected by prior BCG vaccination and are not expected to give a false-positive result in persons who have received prior BCG vaccination.

TUBERCULOSIS SURVEILLANCE FOR PATIENTS

for Behavioral Health 2009.

- VII. COLLABORATED WITH:** Director of Nursing Services, Infection Preventionist
- VIII. RESCISSIONS:** Policy # IC-16, *Tuberculosis Surveillance for Patients of Montana State Hospital* dated September 14, 2009; Policy # IC-16, *Tuberculosis Surveillance for Patients of Montana State Hospital* dated April 24, 2007; Policy # IC-16, *Tuberculosis Surveillance for Patients of Montana State Hospital* dated March 31, 2003; Policy # IC-16, *Tuberculosis Surveillance for Patients of Montana State Hospital* dated February 14, 2000; HOPP #IC-02-96-R, *Tuberculosis Surveillance for Patients of Montana State Hospital*, dated November 14, 1996.
- IX. DISTRIBUTION:** All hospital policy manuals.
- X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review (Attachment B) per M.C.A. § 307-106-330.
- XI. FOLLOW-UP RESPONSIBILITY:** Chairperson of the Infection Control Coordinating Group
- XII. ATTACHMENTS:** None

_____/_____/_____
John W. Glueckert Date/Time
Hospital Administrator

_____/_____/_____
Thomas Gray, MD Date/Time
Medical Director